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No. 93-1203

IN THE
Supreme Court of the United States
OCTOBER TERM, 1993

TIOGA PINES LIVING CENTER, INC., *et al.*,
Petitioners,

v.

INDIANA STATE BOARD OF PUBLIC WELFARE, *et al.*,
Respondents.

On Petition for Writ of Certiorari to the Supreme Court of Indiana

BRIEF OF THE AMERICAN HEALTH CARE ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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AMICUS CURIAE WILL ADDRESS THE FOLLOWING ISSUE:

Whether the Indiana Supreme Court erred by giving inappropriate deference to a state agency concerning its compliance with Medicaid reimbursement requirements under the Boren Amendment when the agency failed procedurally to make mandatory findings of substantive compliance with federal law and when the reimbursement rates were arbitrarily limited without regard to the actual allowable costs that must be incurred by efficient and economical facilities operating in compliance with relevant licensure and certification standards.

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BRIEF OF THE AMERICAN HEALTH CARE ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

INTEREST OF *AMICUS CURIAE*

Amicus American Health Care Association ("AHCA") is a national organization representing health care providers that participate in the Medicaid program, and therefore are subject to the federal reimbursement standards set for the states pursuant to the Boren Amendment, 42 U.S.C. § 1396a(a)(13)(A). AHCA is the largest national trade association representing the long-term care (nursing home) industry. AHCA is a private, voluntary, nonprofit federation of 51 affiliated state associations representing more than 11,000 nonprofit and for-profit nursing facility, residential care, and subacute providers. These facilities care for over one million nursing facility patients, many of whom are beneficiaries of the Medicaid program which annually spends approximately $40 billion

(federal and state funds) on nursing home services for program recipients. Founded in 1949, AHCA remains dedicated to the delivery of quality long-term health care to residents and to the promotion and preservation of standards for professionals serving those residents.

AHCA's interest in this case is its concern that states not adopt Medicaid Plans systematically designed to underreimburse providers, and thereby jeopardize Medicaid recipients' access to quality health care. AHCA recognizes that assuring high quality hospital and nursing home services is a complex process, requiring the hard work and cooperation of many dedicated health care professionals and nonprofessional staff. AHCA also knows that there is a vital link between the ability of providers to assure the availability to patients of high quality care and the adequacy of the reimbursement offered by the government for providing such care. Because Medicaid patients constitute more than 60 percent of the patient census in the nation's nursing homes and because Medicaid dollars represent approximately 50 percent of the gross revenues of nursing homes, AHCA believes that providers must have the means to assure that each state's Medicaid program satisfies the federal standard of "reasonable and adequate" reimbursement rates "meet[ing] the costs which must be incurred by efficiently and economically operated facilities" in compliance with relevant licensure and certification standards.

By utilizing a novel standard of review according unprecedented deference to the state agency, the decision of the Indiana Supreme Court in this case effectively exempts Indiana from having to comply with federal reimbursement standards under Medicaid. If this decision is allowed to stand, it will provide a model to all other states for avoiding difficult state budgetary decisions simply by short-changing the Medicaid reimbursement paid to hospital and long-term care providers (including nursing facilities and intermediate care facilities

for the mentally retarded) for furnishing care to the indigent and the disabled. This result would present facilities with a Hobson's choice: they could incur allowable costs that go unreimbursed, they could withdraw from the business of providing health care or from the Medicaid program, or they could reduce expenditures to meet rate pressures, thereby potentially jeopardizing meaningful access by Medicaid residents to quality patient care.

The decision of the Indiana Supreme Court raises two significant questions. First, as petitioners point out, the Indiana Supreme Court committed profound error by refusing to adjudicate petitioners' federal claims relating to the procedural requirements of the Boren Amendment. Second, by giving cursory treatment and tacit approval to the state agency's adoption of inadequate Medicaid reimbursement rates, the Indiana Supreme Court accorded undue deference to the state agency. AHCA focuses on the far-reaching implications of the latter error in this brief.

Congress envisioned that adequate reimbursement was essential to ensuring the requisite access to, and quality of, care required by the Medicaid Act. These mandates are not attainable without the opportunity for meaningful judicial review, especially by state courts, and without the consistent application of the standards for determining compliance with the federal reimbursement requirements of the Medicaid program. Because any deviation from these mandates is contrary to the explicit language and purpose of the Medicaid statute and to the best interests of Medicaid recipients, AHCA offers its views concerning the importance of this case.[1]

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[1] Pursuant to Rule 37.2 of this Court, the parties have consented to the filing of this brief. The parties' letters of consent have been filed with the Clerk of the Court.

BACKGROUND: THE MEDICAID PROGRAM AND STATE RATE-SETTING METHODOLOGIES

A. The Medicaid Program

Medicaid is a cooperative federal-state program whose purpose is to provide federal grants to states to assist them in furnishing medical assistance, rehabilitation, and other services for the indigent. 42 U.S.C. § 1396. Like other cooperative programs, states may choose between complying with the conditions of the statute or forgoing federal funding. To participate in the Medicaid program, a state must first establish a "State Plan" for medical assistance. *Id.* The State Plan is defined by regulation as a comprehensive written statement that describes the nature and scope of the state's Medicaid program and conforms to the requirements of the Medicaid statute, regulations, and other official pronouncements of the Department of Health and Human Services ("HHS"). 42 C.F.R. § 430.10 (1992). All states and the District of Columbia have opted to participate in the Medicaid program.

The federal statutory requirements that a State Plan must meet are set forth in Section 1902 of the Social Security Act. 42 U.S.C. § 1396a. The operative language of Section 1902 is mandatory; the section begins with the statement, "A State Plan for medical assistance must provide . . .,"[2] and proceeds to enumerate 58 requirements. Among these requirements are the federal standards for reimbursing hospitals, nursing homes, and intermediate care facilities for the mentally retarded for providing health care, commonly referred to as the "Boren Amendment." *Id.* § 1396a(a)(13)(A).[3] This provision states that:

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[2] *Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498, 512 (1990) ("[t]he Boren Amendment is cast in mandatory rather than precatory terms").

[3] Section 1902(a)(13)(A) of the Social Security Act.

> a State Plan for medical assistance must . . . provide for payment . . . of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State) . . . which the State finds, and makes assurances satisfactory to the Secretary [of HHS], are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards . . . .

Id.[4] See also *id.* § 1396a(a)(30)(A) (requiring payment rates sufficient to enlist enough providers to ensure equal availability of care to Medicaid beneficiaries).

At the federal level, Medicaid is administered on behalf of HHS by the Health Care Financing Administration ("HCFA"). HCFA regulations implementing the Boren Amendment require that the State Plan comprehensively specify the methods and standards used by the state Medicaid agency to set payment rates that are consistent with federal Medicaid requirements. 42 C.F.R. § 447.252 (1992). In addition, HCFA regulations require that the

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[4] Since 1988, when the Indiana trial court found petitioners' claims first accrued under the applicable statute of limitations (Pet. C-5), Congress has amended the Boren Amendment in several respects. For example, in 1990 Congress—prompted by the extensive nursing home reform provisions of the Omnibus Budget Reconciliation Act of 1987—further required state payment rates to include:

> the costs of services required to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident eligible for benefits . . . .

Pub. L. No. 101-508, § 4801(e)(1)(A), 104 Stat. 1388-211 (1990). However, since 1981 the Boren Amendment has required states to comply with the basic "reasonable and adequate" reimbursement standard in terms of reimbursing inpatient hospital and long term care services.

participating state make certain findings on an annual basis, as well as whenever the state changes the methods or standards it uses to set payment rates. *Id.* § 447.253(b). In addition to other findings, the state must make a finding that its reimbursement rates comply with the Boren Amendment standards. *Id.* § 447.253(b)(1).

Participating states must also provide assurances satisfactory to HCFA that they have made the requisite findings. *Id.* § 447.253(a). Participating states are not required to submit the findings themselves, or even the supporting data, for review. Thus, HCFA review does not determine whether a State Plan actually complies with the Boren Amendment standards, including having made proper findings and paying sufficient rates, but rather determines whether the state has submitted satisfactory assurances of its compliance with those standards. See *Wilder* v. *Virginia Hosp. Ass'n,* 496 U.S. 498, 507-08 (1990).

B. State Rate-Setting Methodologies

The Boren Amendment grants participating states flexibility in fashioning appropriate methodologies for determining reimbursement rates, so long as the resulting rates meet the federal standards spelled out in the statute. "States [are] free to establish statewide or classwide rates, establish rates based on a prospective cost, or include incentive provisions to encourage efficient operation." *Wilder,* 496 U.S. at 506-07 (footnote omitted). For example, a state using a prospective system could set its rates based on some estimate of allowable costs for the rate period. States using a retrospective system could set interim rates that would be adjusted in some manner based on a facility's actual allowable costs.

In every case, however, the state is required to make annual findings, and to assure HCFA, that the rates established by its chosen methodology are "reasonable and

adequate to meet the costs which must be incurred by efficiently and economically operated facilities" in order to provide access to quality health care to Medicaid recipients. 42 U.S.C. §§ 1396a(a)(13)(A), 1396a(a)(30); 42 C.F.R. §§ 447.204, 447.253, 447.255(b) (1992). Moreover, because the rate-setting methods and standards adopted in each State Plan vary, there may be a zone or range within which reimbursement rates meet the substantive requirements of the statute. Nevertheless, the states have no discretion to set reimbursement rates below the level sufficient to reimburse efficiently and economically operated facilities for the costs that they must incur to meet applicable licensure and certification requirements. Facilities providing care under Medicaid have enforceable federal rights to both (1) proper findings and assurances, and (2) reimbursement rates that actually comply with the substantive Boren Amendment standard. *Wilder,* 496 U.S. at 524; *Suter* v. *Artist M,* 112 S. Ct. 1360, 1367 (1992).

When a Medicaid facility alleges that the State Plan in question does not reimburse it "reasonably and adequately" in compliance with federal standards, the courts —whether federal or state—have evaluated the State Plan on a number of levels. First, the court examines whether the state satisfied its procedural duties. Procedurally, states must, among other things, make annual findings that their State Plans comply with the Boren Amendment and must make satisfactory assurances to HCFA that they have made these findings. Second, the court evaluates whether the actual rates paid are substantively adequate, *i.e.,* whether the rates resulting from the State Plans are "reasonable and adequate" to reimburse providers for the allowable costs they would incur if the facilities were efficiently and economically operated in compliance with relevant licensure and certification standards. Third, the court reviews the State Plan itself to determine whether the reimbursement methodology is arbitrary and capri-

cious. The courts have reviewed these requirements separately even though these duties interrelate to some extent.

In *Wilder*, this Court noted:

> the Courts of Appeals generally agree that when the State has complied with the procedural requirements imposed by the Amendment and regulations, a federal court employs a deferential standard of review to evaluate whether the rates comply with the substantive requirements of the Amendment.

496 U.S. at 520 n.18. However, the Court made plain that it was leaving the deference issue open, and accordingly, "express[ed] no opinion as to which of the cases contain[ed] the correct articulation of the appropriate standard of review." *Id.*

Because of the existence of this open question, reviewing courts have varied widely in their treatment of state agency determinations, at least as to whether a particular State Plan substantively complies with the Boren Amendment by adequately reimbursing providers. Given these varying standards, the geographic location of the facility may determine whether the reimbursement the facility receives for providing care to the indigent and the disabled under the Medicaid program is genuinely adequate. This case presents an excellent vehicle for resolving the conflict among the lower courts concerning how to review state procedural and substantive compliance with the Boren Amendment, thereby ensuring that State Plans provide hospitals and long-term care facilities with "reasonable and adequate" reimbursement as Congress required.

REASONS FOR GRANTING THE PETITION

The primary issues of concern to AHCA are: 1) whether a state court, in reviewing a State Plan challenged for not complying with the Boren Amendment, may simply fashion its own unique standards for reviewing a provider's federal claim, and 2) whether a court should defer to a state agency's interpretation of the standards of the Boren Amendment and its determination that its findings and rates comply with those requirements.

I. COURTS SHOULD APPLY THE *DE NOVO* STANDARD OF REVIEW IN EVALUATING WHETHER A STATE PLAN COMPLIES WITH THE BOREN AMENDMENT'S PROCEDURAL AND SUBSTANTIVE REQUIREMENTS.

As petitioners note, the lower courts are in general agreement that reviewing courts must determine whether the state has made findings in compliance with the procedural requirements of the Boren Amendment and that this inquiry should be undertaken first. See Pet. 19 and sources cited therein. See also *Connecticut Hosp. Ass'n* v. *O'Neill*, No. Civ. 3-90-714, 1994 WL 29998 (D. Conn. Jan. 18, 1994). At the same time, great confusion exists among the lower courts regarding how to review State Plans to determine substantive compliance with the Boren Amendment.[5] This Court itself has recognized that the federal courts of appeals do not apply uniform standards. See *Wilder*, 496 U.S. at 520 n.18. The Court in *Wilder*, however, declined to provide definitive guidance to the

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[5] In the instant case, the Indiana Supreme Court failed even to consider the trial court's determination that the state agency had made no findings to support its assurances that its rates substantively complied with the Boren Amendment. This failure alone makes the court's decision even more incredible and only serves to underscore why this Court should compel the states to satisfy both the procedural and substantive requirements of the Boren Amendment.

lower courts on this issue. *Id.* The need for such guidance has now become more acute as the number of conflicting approaches to standards of review increases almost with every new decision applying the Boren Amendment.

More recent court opinions have noted the difficulty presented by this diversity of reasoning and have attempted without success to reconcile the conflicting opinions. See, *e.g., Department of Health & Social Servs.* v. *Alaska State Hosp. & Nursing Home Ass'n,* 856 P.2d 755, 760 n.5 (Alaska 1993) ("courts have been less than consistent in applying standards of review to Medicaid payment schemes"); *Abbeville Gen. Hosp.* v. *Ramsey,* 3 F.3d 797, 803 (5th Cir. 1993) ("[t]he opinions are not so clear on the proper standard for reviewing substantive compliance with the findings requirement"). In the present case, the Indiana Supreme Court has taken inordinate license with this confusion and has erected and applied an unduly deferential standard of review. As AHCA shows below, despite this Court's previous decision not to resolve the standard of review issue, the Indiana Supreme Court's crabbed conception of review is utterly inconsistent with the legal reasoning of this Court in *Wilder.*

A. Despite The Clear Directive Of Congress, The Lower Courts Cannot Agree On The Correct Standard Of Review.

In *AMISUB (PSL), Inc.* v. *Colorado Dep't of Social Servs.,* 879 F.2d 789 (10th Cir. 1989), *cert. denied,* 496 U.S. 935 (1990), the Tenth Circuit noted that a reviewing court

> must determine whether the plan is procedurally and substantively in compliance with the requirements of the Federal Medicaid Act and its implementing regulations, and not limit its analysis to whether the nonadjudicatory agency findings are arbitrary and capricious.

Id. at 795; see also *Mississippi Hosp. Ass'n* v. *Heckler,* 701 F.2d 511, 516 (5th Cir. 1983) ("A district court

can, of course, decide whether federal law has been violated. Otherwise its review . . . is limited to deciding whether the action is arbitrary or capricious"). Because compliance with the Boren Amendment is an issue of law, the Tenth Circuit reviewed *de novo* the state agency's decision. *AMISUB*, 879 F.2d at 795. After determining whether the State Plan complied with federal law—both procedurally and substantively—the Tenth Circuit as a final matter considered whether the rate-setting methodology the state had used was arbitrary or capricious. *Id.* at 799.

This approach follows the statutory scheme Congress adopted to govern the Medicaid program and to ensure state compliance with Congress' overall objectives. See H.R. Conf. Rep. No. 1479, 96th Cong., 2d Sess. 154 (1980), *reprinted in* 1980 U.S.C.C.A.N. 5903, 5944; S. Rep. No. 471, 96th Cong., 1st Sess. 28 (1979). Therefore, the selection of a particular methodology, and only that decision, should be reviewed under a deferential approach in order to avoid imposing a judicially-mandated choice of methodology on the states.

On the other hand, the Boren Amendment mandates that participating states make findings based on an objective benchmark of efficiency and pay rates that are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" in providing care that conforms to federal quality and accessibility standards. 42 U.S.C. § 1396a(a)(13)(A). This Court has determined that Congress meant for these requirements to be enforced, *Wilder*, 496 U.S. at 514; *Suter*, 112 S. Ct. at 1368, notwithstanding the fact that the states may choose from among the universe of reasonable rate-setting methodologies for calculating appropriate reimbursement rates, *Wilder*, 496 U.S. at 519-20; *Suter*, 112 S. Ct. at 1368. Nonetheless, some rates will never be reasonable. *Wilder*, 496 U.S. at 519-20. Whether state findings, assurances, and rates actually conform to

federal law, therefore, is subject to plenary review. *AMISUB*, 879 F.2d at 795-96.

Despite the fact that this approach is true to the statutory dictates of the Medicaid program as fashioned by Congress and can be applied in a straightforward manner, other courts have created divergent approaches for reviewing State Plan compliance with the Boren Amendment. The problem is that these approaches—seemingly developed to avoid expending the effort this Court noted would be necessary to make an informed inquiry, *Wilder*, 496 U.S. at 520—fail to ensure that the State Plans reviewed actually comply with the Boren Amendment. Of particular importance to this Court's review is that these courts have decided that they will not review *de novo* whether a State Plan substantively complies with the Boren Amendment. See *Abbeville Gen. Hosp.* v. *Ramsey*, 3 F.3d 797, 803-04 (5th Cir. 1993) (arbitrary and capricious standard of review would be used to evaluate substantive adequacy of rates); *Illinois Health Care Ass'n* v. *Bradley*, 983 F.2d 1460, 1462-63 (7th Cir. 1993) (using arbitrary and capricious standard of review to evaluate compliance with federal law); *Pinnacle Nursing Home* v. *Axelrod*, 928 F.2d 1306, 1313 (2d Cir. 1991) (giving deferential review in determining compliance with Boren Amendment); *West Virginia Univ. Hosps., Inc.* v. *Casey*, 885 F.2d 11, 23-24 (3d Cir. 1989) (applying deferential standard of review to assess compliance with substantive standards of Boren Amendment though giving access requirement plenary review), *cert. denied*, 496 U.S. 936 (1990).[6]

Many of these courts have relied on a misinterpretation of the only observation this Court made in *Wilder* concerning standards of review. The Court observed in a

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[6] Even those courts that have employed a relatively deferential "arbitrary and capricious" standard of review have unlike the Indiana Supreme Court subjected state reimbursement rates to some level of meaningful judicial review. *See Abbeville*, 3 F.3d at 804; *Bradley*, 983 F.2d at 1463.

footnote that generally "a federal court employs a deferential standard of review to evaluate *whether the rates comply* with the substantive requirements of the amendment." *Wilder*, 496 U.S. at 520 n.18 (emphasis added). However, the Court never stated that a court should defer to a state agency's understanding of what substantive requirements are imposed by the Boren Amendment itself.

To the contrary, this Court found that:

> Any argument that the requirements of findings and assurances are procedural requirements only and do not require the State to adopt rates that are actually reasonable and adequate is nothing more than an argument that the State's findings and assurances need not be correct.

Wilder, 496 U.S. at 513. As this Court has noted:

> In passing the Boren Amendment, Congress sought to decentralize the method for determining rates, but not to eliminate a State's fundamental obligation to pay reasonable rates.

Id. at 515. The substantive requirements of the Boren Amendment are a matter of federal law and the courts should review *de novo* any state agency's interpretation of those requirements. Deferring to a state agency's judgment of what the Boren Amendment substantively requires, in addition to allowing the state to choose the method it will use to calculate the rates that meet those requirements, is manifestly inconsistent with Congress' decision to impose requirements on the states as a condition of receiving federal money. To hold otherwise would undermine the statute just as surely as permitting states to make procedural findings and assurances that need not be correct, which this Court categorically rejected in *Wilder*, 496 U.S. at 514. The federal standards provided by the Boren Amendment cannot be authoritatively defined by the states that are obliged to comply with them in order to ensure quality health care for the nation's poor. *De novo* review is required.

B. The Indiana Supreme Court Was Able To Evade Its Responsibility Of Reviewing The State's Reimbursement Rates For Substantive Compliance With Federal Law Because Of The Disorder In The Lower Courts.

The Indiana Supreme Court has effectively eviscerated the procedural and substantive requirements of the Boren Amendment by fashioning an entirely new method of review that goes beyond mere deference to the point of blind acceptance. The court noted that it was required to determine if Indiana's State Plan complied with federal law, Pet. A-7, but without discussing the matter further, and entirely ignoring whether the state had even complied procedurally with the Boren Amendment, the court proceeded to ascertain if the manner of calculating rates pursuant to the methodology of the State Plan was rational, Pet. A-15. The Indiana Supreme Court designated this determination "substantive," and limited its consideration of the State Plan to a determination of whether the state agency's use of the Gross National Product/implicit price deflator ("GNP/ipd") index was appropriate. In short, the court conflated the federal requirement of substantive compliance with the leeway a state is permitted in choosing the method used to derive rates that comply with these standards.

By doing so, the court was able to conclude that the Indiana State Plan complied with the substantive requirements of the Boren Amendment simply by deciding that it was permissible to use the GNP/ipd index as part of the rate-setting process to encourage long-term care providers to operate economically and efficiently. There are several serious problems with this approach. First, the Indiana Supreme Court never considered whether long-term care providers received reasonable and adequate reimbursement or if that reimbursement was sufficient to fund care that met the federal standards for quality and accessibility. Indeed, by assessing only the GNP/ipd com-

ponent of the rate, the court violated the fundamental precept that the substantive legality of rates may only be determined by assessing the overall rates rather than their individual components. *E.g., Colorado Health Care Ass'n* v. *Colorado Dep't of Social Servs.*, 842 F.2d 1158, 1167 (10th Cir. 1988); *Wisconsin Hosp. Ass'n* v. *Reivitz*, 733 F.2d 1226, 1233 (7th Cir. 1984). Second, as petitioners note (Pet. 11-13), the Indiana Supreme Court also never determined whether the Indiana state agency had procedurally complied with the Boren Amendment by making the required findings and assurances. This summary form of analysis begs the question of whether a State Plan complies with the requirements of federal law. Likewise, such an analysis cannot be permitted if the Boren Amendment is to have genuine meaning and provide effective control over the states' use of federal Medicaid funds. Because *de novo* review of substantive compliance is required, because the Indiana Supreme Court's standard of review is unprecedented, and in any event, because the issue is clearly unsettled among the lower courts, review of the decision in this case is plainly warranted.

II. STATE AGENCY DETERMINATIONS OF SUBSTANTIVE COMPLIANCE WITH FEDERAL LAW ARE NOT ENTITLED TO DEFERENCE UNDER THE DOCTRINE OF *CHEVRON, U.S.A., INC.* v. *NATIONAL RESOURCES DEFENSE COUNCIL, INC.*

In *Chevron, U.S.A., Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), this Court evaluated a federal agency's interpretation of a statutory term. This Court held that courts should apply a two-step analysis in reviewing a federal agency's action. First, a reviewing court should determine whether Congress has expressed its intent as to the question at issue. *Id.* at 842-43. If it has, then that intent is enforced. However, if Congress has not directly addressed the issue, then the reviewing court looks to the construction given to the statute by the fed-

eral agency *to which Congress has entrusted its administration. Id.* at 844. Deference is then accorded to the delegated authority of the federal agency and, unless its interpretation of the statute is unreasonable, it will be upheld. *Id.*

Courts reviewing state Medicaid Plans disagree as to whether the *Chevron* analysis applies to state agency assertions of substantive compliance with the requirements of the Boren Amendment. See *Illinois Health Care Ass'n* v. *Bradley*, 983 F.2d 1460, 1463 (7th Cir. 1993) (court must review State Plan "with the deference accorded federal agency actions"); *Pinnacle Nursing Home* v. *Axelrod*, 928 F.2d 1306, 1312-13 (2d Cir. 1991) (court must review state agency action deferentially because of HCFA "imprimatur"); see also *Abbeville Gen. Hosp.* v. *Ramsey*, 3 F.3d 797, 802 n.7, 803 (5th Cir. 1993) (giving deference to state agency because of federal agency approval of substantive assurances but rejecting same theory as basis for deference in reviewing compliance with procedural requirements).

But see *Department of Health & Social Servs.* v. *Alaska State Hosp. & Nursing Home Ass'n*, 856 P.2d 755, 760 & n.5 (Alaska 1993) ("the initial determination of whether the agency complied with federal law is *not* entitled to deference"); *AMISUB (PSL), Inc.* v. *Colorado Dep't of Social Servs.*, 879 F.2d 789, 795-96 (10th Cir. 1989) (*Chevron* doctrine applies only to federal agencies interpreting federal law), *cert. denied*, 496 U.S. 935 (1990); see also *Turner* v. *Perales*, 869 F.2d 140, 141 (2d Cir. 1989) (the need for deference to federal agencies to insure coherent and uniform construction of federal law expressed in *Chevron* not applicable to determinations of state agency compliance with federal law); *cf. William Wrigley, Jr., Co.* v. *Wisconsin Dep't of Revenue*, 451 N.W.2d 444, 447 (Wis. Ct. App. 1989) ("whatever deference we may owe to a state agency's expertise and function when it interprets acts of the Wis-

consin Legislature, no such deference is owed when the agency is interpreting statutes or rules of the federal government").

The Indiana Supreme Court, in its effort to uphold the Indiana State Plan at issue here, claimed that "[s]o long as an agency is exercising its discretion, courts must defer to the agency's expertise." Pet. A-8. However, *Chevron* deference does not apply to state agencies in the Medicaid context. As discussed previously, while the states are given some discretion in choosing a rate-setting methodology, no deference should be afforded to the state agency's determination that it has made appropriate procedural findings or its determination that its Plan complies with the substantive requirements of federal law.

It is clear from the Social Security Act that state agencies are *not* entrusted with the administration of the Medicaid statute and that they are *not* exercising congressionally delegated authority when they interpret the substantive standards of the Boren Amendment. The Social Security Act itself entrusts the Secretary of HHS with the administration of the federal medical assistance programs. 42 U.S.C. § 1302. State agencies merely attempt to ensure that the State Plans they administer meet the requirements attached to the receipt of the federal Medicaid grant.

Compliance with federal law is not a discretionary matter for state policymaking. This Court has noted that "a State is on notice that it cannot adopt any rates it chooses and that the requirement that it make 'findings' is not a mere formality." *Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498, 514 (1990). Congress did not intend state agency pronouncements to have the force of federal law. State agencies did not receive a delegation of federal power to make binding policy decisions. Instead, Congress has merely encouraged the states to develop for themselves the methods by which they will comply with

the federal standards it has attached to the receipt of Medicaid grants.

Similarly, the acceptance by HCFA of a state's assurances that a State Plan complies with the Boren Amendment does not amount to a ratification of the state agency's underlying findings, much less its interpretation of federal law. This Court has rejected such a broad conception of HCFA's role since HCFA does not even review the state findings themselves. *Id.* at 508. In fact, one of the avowed purposes of the Boren Amendment was to reduce the degree of HCFA's oversight concerning state Medicaid rate methodologies. *Id.* at 506-08. Consequently, HCFA only reviews whether the assurances appear reasonable. Thus, HCFA's acceptance of a state agency's assurances does not transform the state agency's action into a federal agency action that might be entitled to deference under *Chevron*. Of course, in this case the state never even made procedural findings on which to base its assurances and thus the argument against deference is doubly strong.

In sum, the only way for this Court to ensure that the standards enunciated by Congress in the Boren Amendment are enforced is to require courts to review claims of noncompliance without deferring to a self-interested state agency's determination that it has complied with federal law. Nor should reviewing courts be allowed to escape performing this review—a task "well within the competence of the Judiciary," *id.* at 520, and one that is no more onerous than determining whether any other state action complies with federal law—simply by deferring to agency expertise. The *Chevron* doctrine, based on deference to federal agencies administering statutes pursuant to congressional delegation, should not be expanded to require reviewing courts to defer to state agency interpretations of federal law and accompanying assertions of compliance. Because it rejected the health care providers' claims without meaningful review and because its decision will provide an unfortunate model for

other states wishing to evade compliance with the Boren Amendment, the Indiana Supreme Court's decision warrants review by this Court.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

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